DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0214

MEDICARE QUESTIONNAIRE FOR BENEFICIARIES 65 OR OVER

NAME	DATE OF BIRTH	MEDICARE NUMBER
JOHN Q. PUBLIC	7/23/1935	987654321X

INSTRUCTIONS: **This information will be read by a computer. Please print as shown below. Stay within the boxes. Use CAPITAL letters. Mark boxes with an X. USE BLACK OR BLUE INK.**

EXAMPLE A B C 1 2 3

SECTION A - INFORMATION ABOUT YOU

1) On 7/1/2000 , will **YOU** be working? **YES** [X] **NO** [ ] **(If NO, go to SECTION B)**

2) How many employees, including yourself, work for your employer?

Don't know [ ] 20 or more [X] less than 20 [ ] (If less than 20, **STOP**, go to Section B)

3) Do you have any group health coverage through your current employment?

YES [X] **NO** [ ] **(If NO, STOP, go to Section B)**

Please print the name of your employer, and information about your group health plan in the spaces below:

EMPLOYER NAME
MEGACONGLOMERATE INC

ADDRESS
123 MAIN STREET

CITY
ANYTOWN

STATE
NY

ZIP
11111

NAME OF GROUP HEALTH PLAN
ABC INSURANCE COMPANY

ADDRESS
456 FIRST AVENUE

ADDRESS

CITY
GOTHAM CITY

STATE
NY

ZIP
99999

GROUP IDENTIFICATION NUMBER
AX123TF

POLICY NUMBER
987654321

SECTION B - MORE INFORMATION ABOUT YOU

1) Are **YOU** getting Black Lung (Coal Miner's) Medical Benefits?

YES [ ] **NO** [X] If **YES**, Date Benefits Began: [ ][ ] – [ ][ ] – [ ][ ][ ][ ] (M M – D D – Y Y Y Y)

2) Are **YOU** now getting any medical services related to an illness or injury which occurred on the job, for which **YOU** have or will file a workers' compensation claim?

YES [ ] **NO** [X] If **YES**, Date of Illness or Injury: [ ][ ] – [ ][ ] – [ ][ ][ ][ ] (M M – D D – Y Y Y Y)

If **YES**, Insurer Name

ADDRESS

ADDRESS

CITY

STATE

ZIP

SAMPLE

3) Are YOU now getting any treatment for an illness or injury for which another party could be held responsible or could be covered under no-fault, automobile, or liability insurance?

YES [X] NO [ ] If YES, Date of Illness or Injury: 05 (MM) - 03 (DD) - 1999 (YYYY)

If YES, Insurer Name

ACME NOFAULT INSURANCE

ADDRESS

PO BOX 789

ADDRESS

CITY METROPOLIS STATE NY ZIP 99998

SECTION C - INFORMATION ABOUT YOUR HUSBAND/WIFE

1) On 7/1/2000 , will your husband/wife be working? YES [ ] NO [X] N/A [ ]

(If NO or N/A, STOP, sign bottom of form)

Husband/Wife's Name

FIRST Middle Initial Husband/Wife's Social Security Number

LAST

2) How many employees, including your husband/wife, work for your husband/wife's employer?

Don't know [ ] 20 or more [ ] less than 20 [ ] (If less than 20, **STOP**, please sign below)

3) Does your husband/wife have group health coverage through his/her employment? YES [ ] NO [ ]

(If NO, STOP, please sign below)

What type of coverage does your husband/wife have under this health plan?

Worker only coverage [ ] Family coverage (husband/wife) [ ]

Please provide the name of the employer, and information about the employer group health plan in the spaces below:

EMPLOYER NAME

ADDRESS

CITY STATE ZIP

NAME OF HEALTH PLAN

ADDRESS

ADDRESS

CITY STATE ZIP

GROUP IDENTIFICATION NUMBER

POLICY NUMBER

Your Signature Is Required John Q. Public

AREA CODE PHONE NUMBER 555 - 5555 - 1234

SAMPLE